BULLETIN OF THE MAHONING COUNTY MEDICAL SOCIETY VOL. 66 NO. 4 JULY-AUGUST 1995

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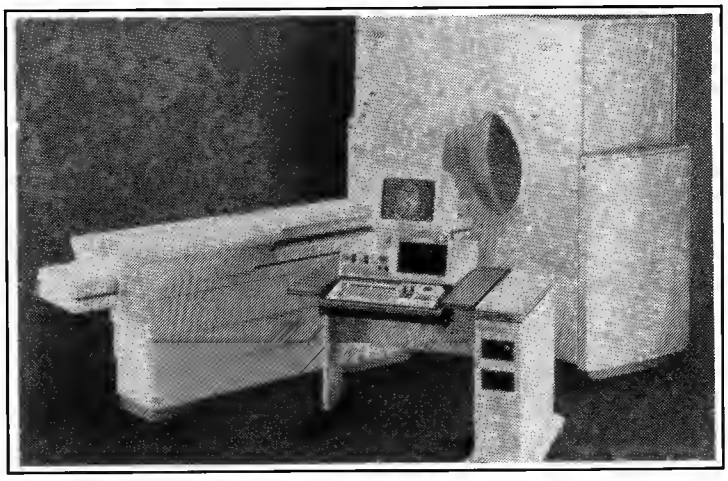

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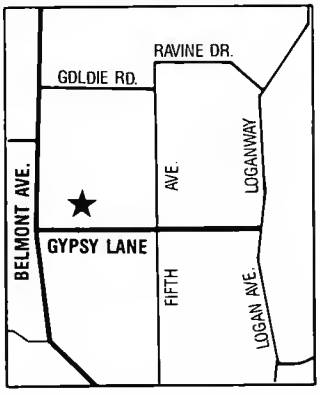

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BULLETIN

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From the Desk of the Editor

Health Care Reform: Hospital and Outpatient Facilities

IN PREVIOUS ARTICLES, WE HAVE DISCUSSED POSSIBILITIES FOR THE APPROPRIATE CONTROL OF PHYSICIANS' PRICES AND THE CONTROL OF the number of times these services are requested. However, that sector of the medical field accounts for (approximately) only 20% of the entire cost of medical care in this country. Hospitals and outpatient facilities (such as ambulatory centers, labs and radiology units) account for a much larger portion of the Total Cost, and they have proven to be incapable of controlling their own costs.

With this in mind, I see no reason why the same system we discussed in earlier articles for controlling costs in the physician sector would not be effective in the hospital sector as well. That is, an appropriate organization of persons and professionals for each type of facility could decide a fair and reasonable price for each service provided in that particular area of the country. Remember our P.O.P.S. pricing system for physicians? This could be called the Hospital Organization Pricing System, or H.O.P.S. For hospitals, the administrative head of such an organization could be the American Hospital Association. This group would decide, on a yearly basis, the appropriate charges for each CBC, room, meal and aspirin provided by such an institution.

David E. Pichette, M.D.

David E. Pichette M.D.

A facility choosing to abide by these guidelines would be entitled to display on its door an identifying symbol similar to the one previously described for the physicians' system. The same rules would apply — only hospitals abiding by the H.O.P.S. rules and price guidelines could display the symbol. If even one item cost $1.00 more, the symbol would have to be removed — and "the buyer beware". If Beverly Hills Memorial Hospital wanted to serve lobster three nights a week and charge twice the H.O.P.S. rate for its rooms, fine, but they could not display the symbol. That way, the public would be aware of the institution's pricing policies.

As with the physician system, prices within the H.O.P.S. would be allowed to increase no more than a fixed economic index. If inflation were 3.1%, that would be the highest percentage facility prices should increase. If new technology could not be afforded on such increases, it would be understood that the country in general could not afford the technology, and those involved would simply have to wait.

If, however, St. X Hospital could afford a new MRI machine on a 3.1% increase, then St. Y Hospital had better find a way to do the same, in order to stay competitive. Other non-medical hospital enterprises (like selling its highly-demanded O.R. scrub suits) obviously would not be so governed.

In order to control demand of facility services, the patient would be required to pay a percentage of the total cost of each visit. Mind you, this is a *percentage,* not a co-pay or deductible, and it would have a yearly cap based on the patient's means. This should not be regarded as unfair to the more fortunate, but rather, an equitable means of giving others a break that would be fair to them as well. Being spread among the population, the break would be reflected in overall price determination.

If this were the case, patients would want to leave the hospital sooner so that their costs

continued on pg. 32

President's Page

Legislative/Community Relations Activities Scheduled for Fall

AS I SIT DOWN TO WRITE THIS ARTICLE, I AM AMAZED TO REFLECT THAT SUMMER IS NEARLY OVER. THE COUNCIL OF THE Mahoning County Medical Society traditionally suspends its monthly meetings for the summer, and this summer was no exception. As the fall approaches, it is time to start gearing up for the anticipated activities along the legislative and community relations fronts.

". . .The delivery of health care in this community is about to go through a significant transformation. . ."

Hopefully, you have received and read the communications from the Society concerning the OSMA's call for action on the issue of managed care fairness and the AMA's request for action regarding Medicare reform. These specific issues will be addressed as the House of Representatives at both the state and national levels return to work this fall. The OSMA is requesting specific examples where patients' health has been jeopardized by adverse managed care administrative decisions. Such examples will help the OSMA to present its case for introduction of the Managed Care Fairness Act.

The U.S. Congress will address the issue of Medicare reform this fall, and the AMA has stepped forward with its own proposal for restoring fiscal responsibility. Please contact Congressman Traficant to ask his support for the AMA's plan. (A copy of this plan has already been forwarded to him by the Society.)

It is my understanding that the issue of tort reform has been placed on the front burner. A select committee on tort reform has been established in the Ohio House, chaired by Rep. Jim Buchy [R] of Greenville. Hearings will take place in the near future. The Nurse Practitioner Act, on the other hand, is moving at a slower pace. I have been informed that the Ohio Family Practice Association has agreed to prescriptive authority for the nurse practitioners. It appears to me that our legislators are receiving mixed messages, and this begs for better communication among our respective professional societies. At this time Sen. Grace Drake [R], Chair of the Senate Health Committee, has strong reservations regarding prescriptive authority.

In the area of community relations, the Society has been actively engaged in preparing a forum on Managed Care. This forum will be open to the general public, and is scheduled to take place November 16th at Youngstown State University. The Society has been workng with Mr. Thomas Flynn, Director of the Lake to River Coalition, to coordinate the event. Participants will include representatives of provider groups, managed care entities, labor, government, and the insurance industry. Dr. Dan Johnson, president-elect of the AMA, will return to Youngstown to participate in this community event. Please mark you calendars and plan to attend.

Health system reform continues at the market level and is making significant inroads in the community. Ohio Care, the Medicaid reform program, is currently on hold. The delivery of health care in this community is about to go through a significant transformation, and it behooves the physicians of this county to help patients prepare for the changes to come.

Daniel W. Handel, M.D.
President

Daniel W Handel, M.D.

Cybercare

ON THE COVER OF APRIL'S *NARD* (NATIONAL ASSOCIATION OF RETAIL DRUGGISTS) MAGAZINE IS A PHARMACIST BEING squeezed by a boa constrictor armed computer with keyboard teeth and a scowling face for a screen. The caption reads "Electronic Prescriptions — Will Independents be squeezed out?"

The age of "Surfing the Internet" and computer-assisted applications of tasks formerly done manually has arrived and promises to intensify in scope and function. One application not fully in place now, but emerging on the horizon, is the practice of transmitting prescriptions electronically.

Electronic prescriptions will be information transmitted via an EDI (Electronic Data Interchange) from physicians to pharmacists. Proponents of this future application feel electronic prescriptions will:

1. Decrease the time a pharmacist spends phoning for prescriptions.
2. Decrease the time a physician spends writing prescriptions.
3. Allow physicians and pharmacists to share each other's data as needed.
4. Allow physicians to exercise "point of prescribing" DUR (Drug Utilization Review), i.e.:
   a. Patient Compliance Information
   b. Drug Interactions/Precautions
   c. Formulary Prompts
   d. Drug Histories (Medication Profile System)

The onset of these technological advances, although appealing from a time/intervention perspective, has its dangers.

1. Conflict of interest on the part of the drug manufacturers — PBMs (Prescription Benefit Managers, i.e., PAID/PCS/DPS) are now owned by drug manufacturers. PBMs currently abuse their ability to access information regarding a patient's medication regimen. Examples include on-line formulary prompts at the time of dispensing in pharmacies and phone calls/letters to physicians to switch a medication to a cost-effective, or company-owned product. What will happen if they have access before a prescription is written?
2. Confidentiality of Patient Records — See above. Every model currently being studied on electronic prescriptions has extraneous parties involved besides the physician and the pharmacist.
3. Patient Freedom of Choice — Patients may be alerted prior to leaving a physician's office of the company-approved pharmacy providers. This will deny patients the freedom to choose any provider willing to accept the terms set by the insurance company and funnel them to "company-friendly" practitioners. A worst-case scenario has the data transmitted to a PBM-owned mail-order pharmacy on the patient's behalf. At that point the mailman becomes the pharmacist.

This issue should be interesting and hotly debated. The utopian outcome would be a confidential electronic interaction between healthcare professionals with limited outside influences.

John A. Petracci, R.Ph.
Chairman of the Board
Eastern Ohio Pharmacists Association

NEOUCOM to Recognize Teaching Excellence

JOHN D. ENGEL, PH.D., VICE PRESIDENT FOR ACADEMIC AFFAIRS AND EXECUTIVE ASSOCIATE DEAN AT THE NORTHEASTERN OHIO Universities College of Medicine (NEOUCOM), has introduced a Master Teacher Program to recognize faculty who have consistently excelled as teachers, and to use their collective talents to enhance the educational programs at the College. NEOUCOM is the first medical school in Ohio to institute such a program.

The program was developed by John J. Docherty, Ph.D., NEOUCOM professor and chairperson, microbiology/immunology, and Robert T. Brodell, M.D., NEOUCOM professor of internal medicine and head, Dermatology Section based at Trumbull Memorial Hospital in Warren. It has been endorsed by the College's Overall Curriculum Committee and approved by the Academic Council.

According to Docherty, "The goal of the program is to recognize the College's best teachers and to have them serve as consultants and mentors. Ph.D.'s, M.D.'s, medical students, graduate students, residents and fellows currently do not receive formal training in pedagogy at NEOUCOM or at the majority of other medical schools. Nonetheless, they are expected to teach, and teach effectively, at the very highest rung of our educational ladder."

"For those individuals with a natural aptitude for the educational arena, success comes readily. For others, the classroom experience is difficult. However, all of our faculty and students can be guided to be more effective teachers," Brodell added.

According to the terms of the program, assistant, associate or full professors at NEOUCOM can be nominated by any member of the College community. One member from each College of Medicine department/office may be nominated each year. The name of the nominee will be forwarded to the director of the division in which that department/office resides. The Division of Clinical Sciences may nominate three individuals per year, the Division of Basic Medical Sciences, two, and the Division of Community Health Sciences, one. Multiple criteria will be considered as documentation of teaching excellence, including student evaluations, faculty/administration evaluations, and academic activities. The credentials of the nominees will be forwarded to the Faculty Appointments and Promotions Committee for final review and selection. Up to six Master Teachers will be named at the College's annual Founders Day program in November.

The initial appointment as a Master Teacher will be for a term of three years. All Master Teachers will be reviewed during their third year and considered for reappointment. If a faculty member successfully completes three consecutive terms, the designation "Master Teacher" will become permanent. For tenure track faculty members, recognition as a Master Teacher will assist in demonstrating excellence in one component of the tenure review process — education. For non-tenure track members, achieving Master Teacher status will contribute to their promotion process.

Individuals who achieve the status of Master Teacher will be expected to provide leadership in the area of education at NEOUCOM by developing innovative educational methods and training faculty and graduate students in effective teaching methods. This training may be provided in formal presentations and through a program of mentoring for junior faculty.

Engel explained that the program "will serve as a concrete example of the College of Medicine's commitment to provide the best possible educational experience for each NEOUCOM student. In addition, if we can document success in these endeavors, this program could serve as a national model to be followed by other medical schools."

On The Cover

"Rugged Terrain"

Jo Hodos
Oil, 11″ × 14″

THIS MONTH'S FEATURED ARTIST ADDS TO THE LIST OF ARTISTS WITH UNUSUALLY GIFTED TALENT. BORN IN APRIL, 1939, IN Youngstown, Jo Hodos began painting at the age of 10 when her brother and sister-in-law gave her a set of oils. From there she has never stopped painting. A graduate of Woodrow Wilson High School in 1957, Jo soon married and began raising a family. In spite of a busy life, she never wavered from the pursuit of painting, and through trial and error over the years she formed her own technique of painting. She did seek advice and critique of her work from local artists to guide her progress, but what you see here is a beautiful gift nurtured to maturity.

Years ago, Jo began the familiar path of attending outdoor shows. She still remembers "lugging easels and paintings of all subject matters, and spending long hours and rainy days to sometimes sell a few paintings". Most of those still lifes and landscapes would show a horse somewhere in the view. As time passed Jo began doing mostly equine paintings. Those outdoor shows led by chance to a big break in her career. A man suggested she enter her work at the annual Harness Tracks of America Art Auction at Red Mill in Lexington, Kentucky. Three years later Jo followed that suggestion and began a very successful showing with the following years bringing many awards and ownership of her works by the owners of Woolworth Chain, Wallenius Cruise Lines, Almahurst Farms, Minnesota Vikings to name a few.

Jo travels to many county fairs and horse shows where she takes photographs, using them for her paintings and adding or changing horses, people or backgrounds to suit the mood of each painting. She then begins with a rough sketch on canvas with charcoal and precedes with a wash of cobalt blue or umber. Oil is her medium. It provides the rich texture Jo loves to work into the canvas. The oils are applied in short strokes to create a sense of movement with a more intensified play of light and shadow. "Some places I'll leave the brush look and others I'll start heavier with a palette knife. I like to get an impressionistic look so that when you stand back, it forms into something." Jo usually keeps to small canvases, rarely exceeding 22″ × 24″.

To view a group of Jo's small paintings is like gazing upon a jeweler's tray of diamonds. Each is so rich in color and brilliance, so beautiful and perfectly executed with an impressionistic flair. Viewers are drawn into her paintings and feel a kinship with the images. The thickness of paint on the canvas makes the whole image alive and you want to reach out and touch such an exuberant and tangible language. These are the qualities of a real master.

Jo's resume runs several pages of shows, exhibits, and awards across the United States. She has been featured in prestigious national magazines, and most recently became one of 56 finalists from 9,500 entries in the animal category of The Artist's Magazine. She maintains a studio in her Boardman, Ohio home.

Jeannine M. Lambert

Jeannine M. Lambert

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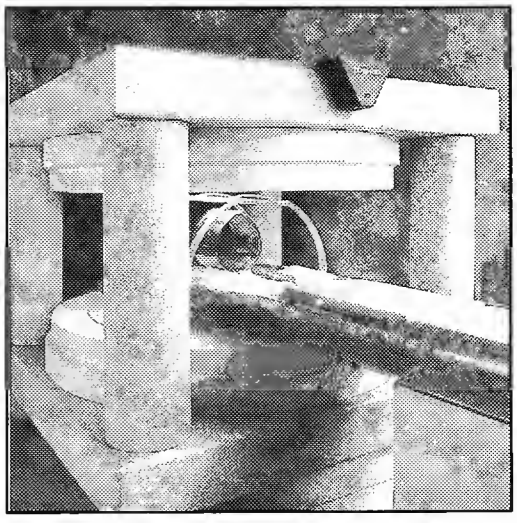

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Galterius Grajo, M.D.

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- Trained LSU Medical Center and Children's Hospital of Pittsburgh
- 13 years Radiologist at Northside Medical Center

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OSMA

Legislative Update

OHIO-CARE ALTERNATIVE...HOUSE BILL 120, WHICH PRIVATIZES HEALTH-CARE COVERAGE FOR MEDICAID AND OTHER low-income Ohioans, is likely to appear before the full House later this fall. The fate of the bill, recently approved by the House Insurance Committee, will depend on whether or not Congress will release block grants to states to run their Medicaid programs. Vouchers would offer eligible individuals access to privately delivered health insurance coverage, and those between 100% and 225% of the poverty level could pay premiums on a sliding scale. **OSMA position:** Under advisement.

Physician Assistants' Bill New in House... Senate Bill 143, sponsored by Sen. Grace Drake (R-Solon), has been passed in the Senate and now moves to the House for discussion. The bill revises the laws pertaining to physician assistants and allows PAs to be employed by institutions as well as by physicians (although no prescription authority is mentioned in the bill). **OSMA position:** The OSMA generally opposes the corporate practice of medicine, so it has taken a position of opposition on this bill.

EXAMPLES NEEDED OF
HOW MANAGED CARE POLICIES ADVERSELY AFFECT PATIENTS

In order for the OSMA to strengthen its arguments in support of the **Managed Care Fairness Act,** which the OSMA developed, help is needed in identifying local examples that demonstrate the need for this bill.

THE OSMA IS INTERESTED IN THE FOLLOWING INFORMATION:

1. Concrete examples **where patients' health has been jeopardized** by practices that:
   - Forced them to leave your care at a critical point in their treatment, thus continuity of care was lost.
   - Delayed or denied approval for treatment deemed necessary **and then suffered adverse health effects because the treatment was delayed or not provided.**
   - Imposed unreasonable UR requirements.
2. If you have **been terminated without cause** from a plan and lost substantial numbers of patients as a result.
3. Cases where treatment was approved by the managed care plan and then later denied, leaving you without payment for your services.
4. Patients who brought legal action against their health plan because of adverse health effects of a managed care policy or practice.

PHYSICIANS ARE NOT ASKED TO DIVULGE THE NAMES OF PATIENTS, ONLY TO INFORM THE OSMA OF THEIR PERSONAL EXPERIENCE WITH REGARD TO NEGATIVE MANAGED CARE SITUATIONS.

PLEASE SEND EXAMPLES TO: Ohio State Medical Association
Department of Legislation
1500 Lake Shore Drive
Columbus, Ohio 43204-3824

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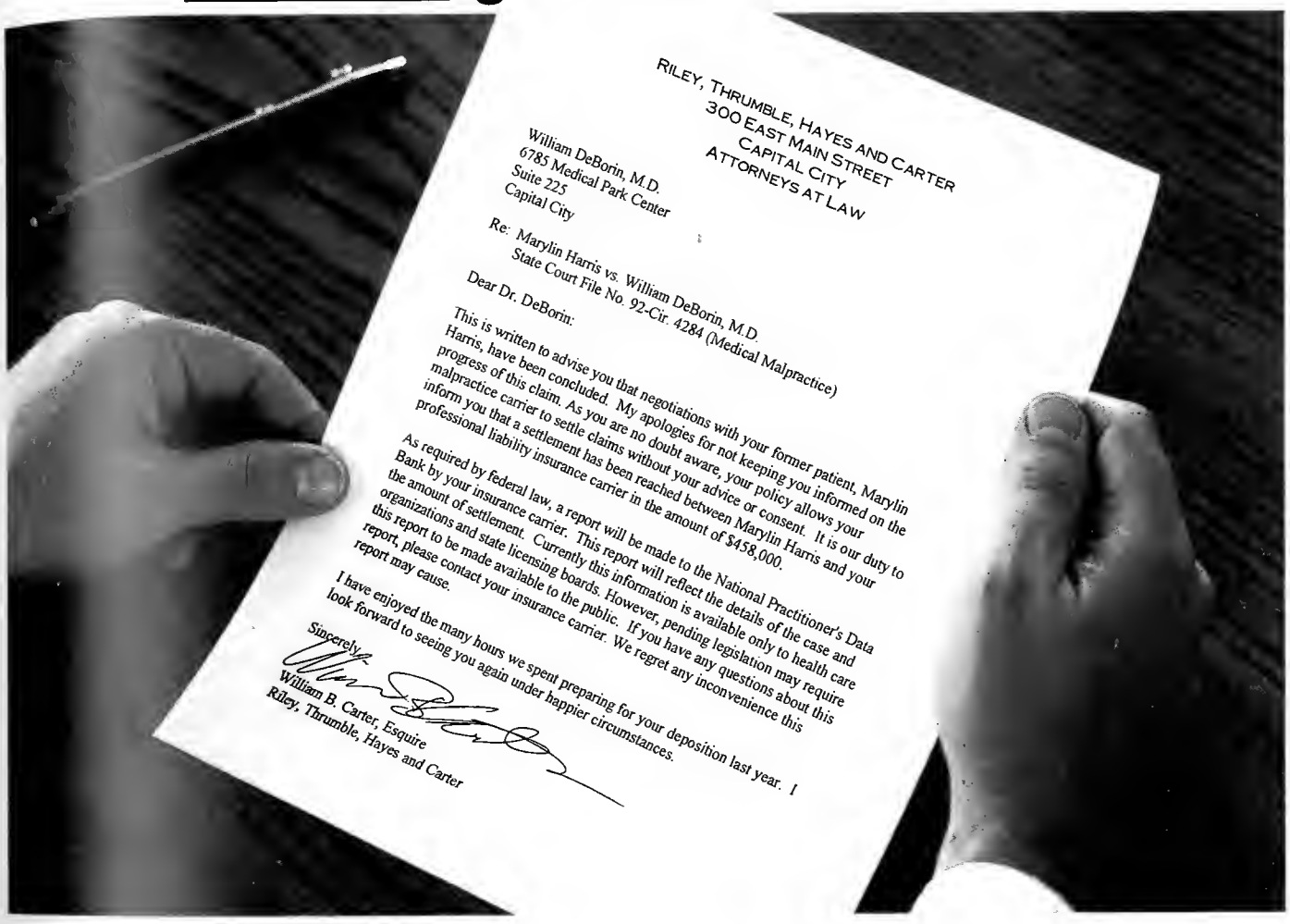

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300 EAST MAIN STREET
CAPITAL CITY
ATTORNEYS AT LAW

William DeBorin, M.D.
6785 Medical Park Center
Suite 225
Capital City

Re: Marylin Harris vs. William DeBorin, M.D
State Court File No. 92-Cir. 4284 (Medical Malpractice)

Dear Dr. DeBorin:

This is written to advise you that negotiations with your former patient, Marylin Harris, have been concluded. My apologies for not keeping you informed on the progress of this claim. As you are no doubt aware, your policy allows your malpractice carrier to settle claims without your advice or consent. It is our duty to inform you that a settlement has been reached between Marylin Harris and your professional liability insurance carrier in the amount of $458,000.

As required by federal law, a report will be made to the National Practitioner's Data Bank by your insurance carrier. This report will reflect the details of the case and the amount of settlement. Currently this information is available only to health care organizations and state licensing boards. However, pending legislation may require this report to be made available to the public. If you have any questions about this report, please contact your insurance carrier. We regret any inconvenience this report may cause.

I have enjoyed the many hours we spent preparing for your deposition last year. I look forward to seeing you again under happier circumstances.

Sincerely,

William B. Carter, Esquire
Riley, Thrumble, Hayes and Carter

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SPECIAL REPORT

Practice Integration Rising Among Our Readers

OUR 1995 READER SURVEY #1 REVEALS GROWING PRACTICE SIZE AND INCREASING MOVEMENT TOWARD MERGER, NETworking and PHO/MSO organization. That's a big change from just over a year ago, when there was more talk than action.

Almost half of our readers have made significant organizational changes. Responding to our questions about *specific* steps you've taken, you told us that managed care has forced doctors to do more than just talk about restructuring. If you aren't yet active, you may find yourself behind the eight-ball.

While a slight majority (55%) of respondents still resist major change, 45% of you have integrated in one or more of these ways:

- Joined a "network" of physicians actively operating as an IPA or similar entity — 61%.
- Joined a hospital-affiliated PHO, MSO, etc. which is actively in operation — 53%.
- Joined an actively functioning "group without walls" — 10%.
- Accomplished a true merger with another group(s) — 9%. (Of those who merged, most (78%) joined another practice(s) of the same specialty and fewer (22%) went into a multispecialty group.

We saw no significant variations by practice size (number of doctors), but there were noteworthy differences according to region and specialty. The Rocky Mountain region, where managed care has taken hold at least in the large cities, shows by far the most practices (58%) taking significant integration steps. Midwestern states report the least change; only 33% of respondents have taken active steps, which is still a hefty shift in strategies over just two years. We suspect the Mid West — indeed, the rest of the country — will catch up with the Rockies and the Far West (second in activity at 53%) over the next few years.

Sold Out?

Fortunately in our view, only 7% of respondents have sold their practices. (Of them, almost half also reported integrating in one or more of the ways listed above.) Hospitals and medical schools were the buyers in most (40%) of the identified cases. The rest of the sales were scattered among another practice, an insurance company, a for-stock private company (like PhyCor and Coastal) and a large batch of "other."

Twice as many primary care physicians have sold out as have doctors in general — 14% compared to 7%. The "PCPs" are, of course, the most attractive players in managed care, so it's no surprise that they're the ones getting the best prices. We believe PCPs are such a hot commodity that they'll do better by staying independent (though well networked) than by selling out.

Growing Bigger, Too

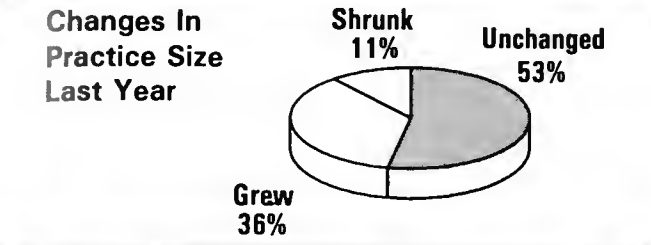
Practice size is increasing even though we sense a decline in the number of small practices recruiting new doctors. The average number of physicians in all our respondents' practices is 5.4 doctors, with PCPs averaging slightly lower at 4.7 and hospital-based groups (the "RAPs") at a large 15.9.

Just over half (53%) of our readers stayed un-

Editorial Note: We acknowledge the cooperation of Leif Beck, who has granted reprint rights for topics which have appeared in his regular monthly publication, The Physician's Advisory. His organization, The Health Care Group, with offices in Plymouth Meeting, PA, is a group of leading national consultants and attorneys specializing in medical practice organization and management.

continued on next page

changed in practice size over the past two years. Most of the rest (36%) increased group size, while the remaining 11% shrunk, as shown by this circle graph:



We were surprised at the specialty breakdown on practice growth. More specialty and subspecialty internists (49%) added doctors than any other classification, while only 11% of them decreased group size. The RAPs also grew dramatically, as 44% of them added physicians; half of those groups added three or more doctors in the two-year span. The RAPs, by the way, also reported the most shrinkage — 19% have fewer doctors than two years ago.

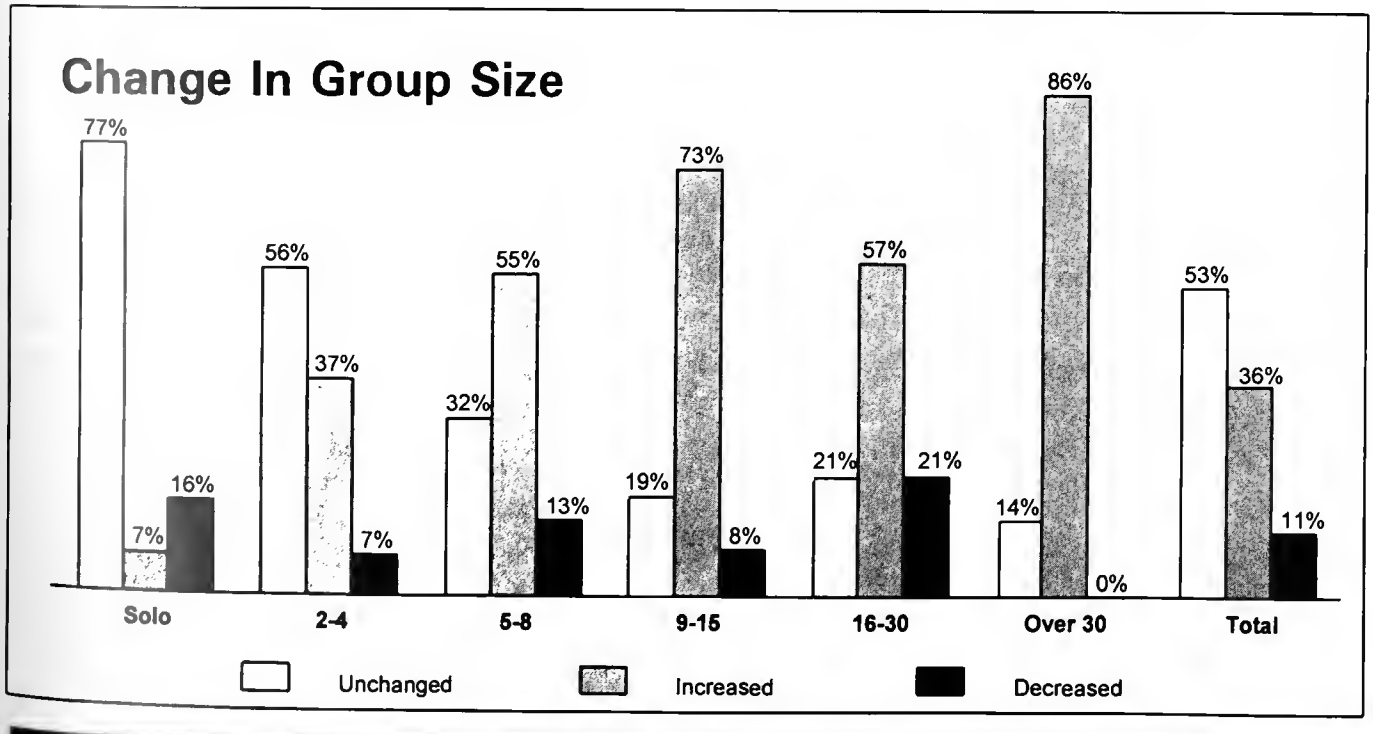
The bar charts below show the breakdown on size changes by practice size. It's interesting to see so much growth in the smaller groups.

OPTIMISM FOR CONTINUED INDEPENDENCE

We asked what you expect your practice or group to be like two years from now, fully anticipating heavy concern for lost independence. We found it encouraging that the great majority of Advisory readers expect to remain in control of the way they work.

82% expect to remain in independent, private practice, of which almost two-thirds (63%) expect to be part of an integrated system or network and the rest (37%) believe you will continue fully independent without such arrangements. That's good to see, indicating that commitment to doctor-controlled independent practice remains strong. Still, we think independence will work best through some sort of network or system.

Of the remaining respondents, 10% expect to be part of systems they don't control. Another 6% expect their practices or groups will be owned by a hospital, managed care plan, insurer or other private company. The last 1% say their practice or group will be "out of existence," with the doctors either pure employees or retired.

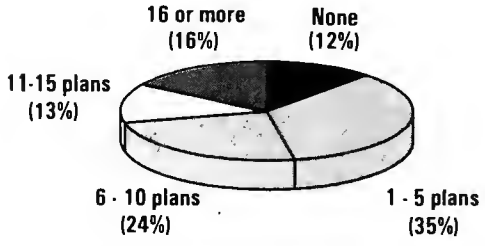


Inexorable Increase in Managed Care Contracts

1995 Reader Survey #1 shows the trend in every size practice, among all specialties and throughout the country. It looks almost sure to continue, so read and heed!

Only 12% of responding physicians are not under contract to provide patient care for any managed care plans at all. Except for these outliers, doctors work with an average of 11.6 plans. Here are the averages:

Percentage of Practices Serving Various Average Numbers of Plans



We looked at the responses of just the 88% contracted to at least one plan. By specialty, dermatologists and allergists seem to join everything available; they average 28.1 plans per practice. All other specialties are close to the 11.6 plan average. Not surprisingly, physicians in the Far West (California, Oregon and Washington) participate in many more plans per practice — 23.9 — than in any other region.

Patient Numbers

Almost all (93%) practices now have managed care patients, and — excluding those with none — these patients total an average one-third of the doctors' patient count. Not surprisingly, the contracted load is heaviest in large and multispecialty groups and in the Far West, where practices average 50% managed care.

The numbers are steadily rising. In just the last two years, the average managed care patient load rose from 18% to 25% and now to 33%. If this trend continues, and it's foolish to think otherwise for at least the next few years, 68% of your patients will be contracted to you by the year 2000!

The growth in managed care is remarkably uniform among all specialties, practice sizes and regions of the country. The table in the next column shows this trend, along with a corresponding trend toward relying on one very active plan.

The Steady Spread of Managed Care

	% Managed Care Patients			% in Most Active Plan		
Size	**Now**	**1 yr. ago**	**2 yrs. ago**	**Now**	**1 yr. ago**	**2 yrs. ago**
Solo	35%	27%	19%	13%	11%	8%
2-4	32%	24%	17%	13%	11%	8%
5-8	31%	23%	17%	12%	9%	7%
9-15	32%	26%	19%	12%	10%	8%
16-30	41%	34%	28%	15%	14%	13%
Over 30	48%	41%	39%	23%	26%	26%
Total	**33%**	**25%**	**18%**	**13%**	**11%**	**9%**

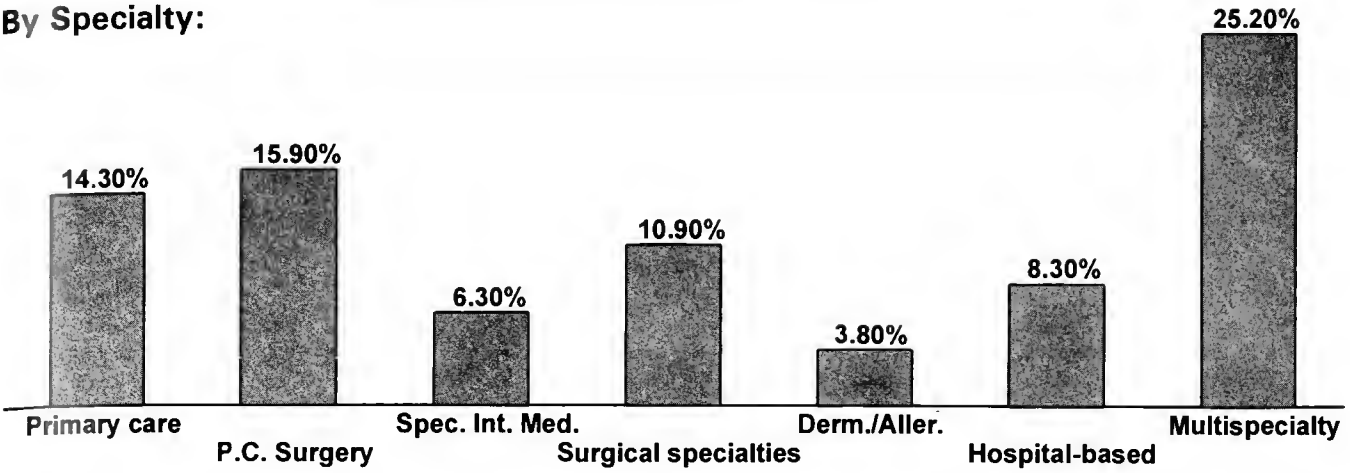
	% Managed Care Patients			% in Most Active Plan		
Region	**Now**	**1 yr. ago**	**2 yrs. ago**	**Now**	**1 yr. ago**	**2 yrs. ago**
One	36%	25%	17%	13%	11%	8%
Two	29%	23%	16%	13%	11%	10%
Three	32%	23%	15%	12%	9%	6%
Four	30%	24%	18%	12%	10%	7%
Five	39%	31%	24%	15%	14%	11%
Six	50%	42%	30%	18%	15%	12%
Seven	29%	19%	15%	11%	9%	6%
Total	**33%**	**25%**	**18%**	**13%**	**11%**	**9%**

	% Managed Care Patients			% in Most Active Plan		
Specialty	**Now**	**1 yr. ago**	**2 yrs. ago**	**Now**	**1 yr. ago**	**2 yrs. ago**
Primary Care	39%	31%	24%	15%	12%	10%
P.C. Surg.	32%	23%	17%	13%	11%	8%
Spec. Int. Med.	26%	20%	14%	12%	10%	8%
Surg. Spec.	31%	22%	15%	13%	11%	8%
Derm./All.	39%	29%	18%	12%	10%	5%
Hospital	35%	29%	23%	10%	8%	7%
Multi	49%	41%	35%	25%	27%	26%
Other	34%	24%	12%	10%	10%	8%
Overall	**33%**	**25%**	**18%**	**13%**	**11%**	**9%**

We're concerned about this latter statistic, though the trend is probably inevitable. The tables show that, over the past few years, the number of patients in your single most active managed care plan is steadily rising at two percentage points per year. It now averages 13% of your patients, having gone from 9% in 1993 to 11% in 1994.

We've long advised against becoming too dependent on any one managed care contract, particularly expressing concern if more than 20% of your patients are in a single plan. Most of you are not yet to that point, but we fear you will exceed it even before the accompanying table suggests. That's because of the rapid consolidation among managed care companies, which will almost surely leave you dealing with fewer and larger plans.

By Specialty:

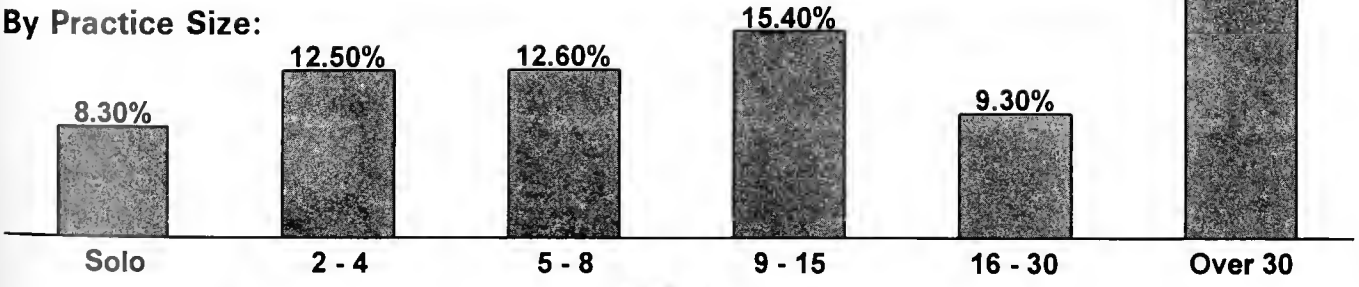


Capitated Practice — It's Growing Slowly But Surely

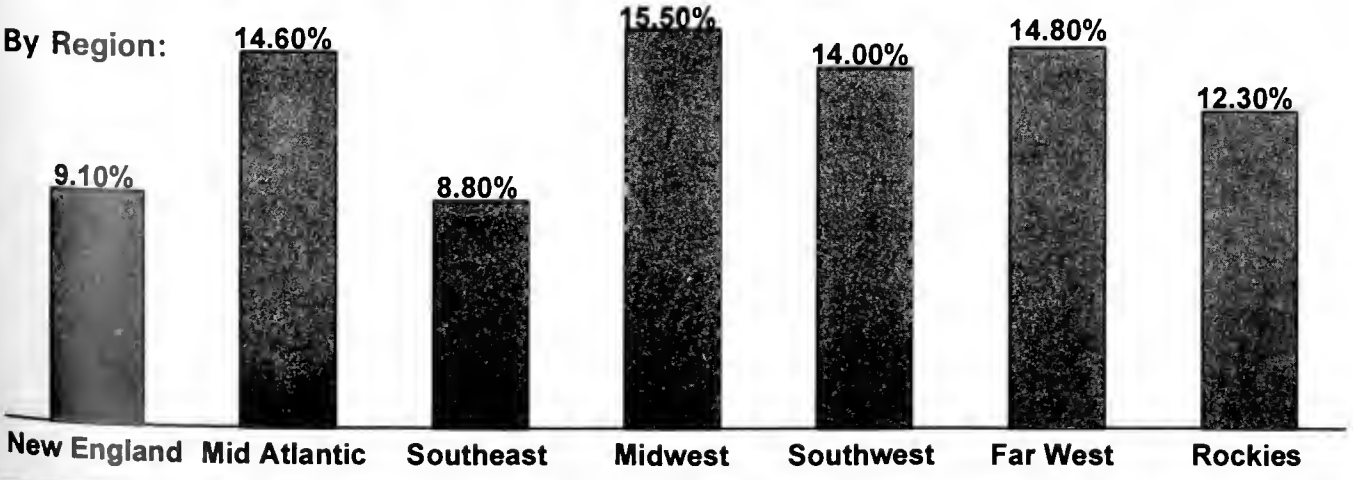
Only one in five practices has ventured into the capitation minefield. Among those doctors, capitated patients represent an average 12.8% of their total active patient count. If you are into cap rate work, these bar graphs let you compare your activity level with others in your specialty, practice size and location who also handle such contracts. The bars represent percent of a practice's patients who are capitated.

Though the number of readers involved in capitated care is still small, it has grown fast over the last couple of years from nearly zero. We'll keep advising about it because it's so important to future success.

By Practice Size:



By Region:



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From the Bulletin

A Look Back . . .

Sixty Years Ago
July/Aug. 1935

The Society voted the use of the Municipal Hospital on Indianola Avenue (the contagious disease hospital) as a psychopathic hospital. The Depression was in full swing, and most of the patients were on relief. Money was appropriated from the State on the basis of $1.00 per family per month. When the money was insufficient, the doctors' bills were prorated. Since this was most of the doctors' incomes, the doctors were not happy. Doctors in Trumbull and Columbiana counties went on strike. No comment on how that was settled.

Fifty Years Ago
July/Aug. 1945

Walter F. Bartz died while a prisoner of the Japanese. **Nathan Belinkey** was also a prisoner, somewhere in Japan. **William Skipp** was elected president of the Medical-Dental Bureau. Majors **William Neidus** and **Samuel Tamarkin** were home on leave. **Carl Raupple** and **Clarita Hovirson** were married. Major **Sam Goldberg** was in Germany. **Walter Tims** was spending a couple of weeks on the Riviera. **J.L. Fisher** was in the Philippines, passing a kidney stone.

Forty Years Ago
July/Aug. 1955

Officers were: **Ivan Smith**, president; **G.E. DeCicco**, president-elect; **Andrew Detesco**, secretary; and **A.K. Phillips**, treasurer. Editor **Bob Tornello** was trying to interest the membership in helping to finance a new theater for the Youngstown Playhouse. (Bob is currently the chairman of the board of the Playhouse.) There was an unsigned article in the July issue reporting that the National Cancer Institute was studying the relationship of lung cancer in the population to smoking habits. New member was **James L. Finley**. **Arthur C. Tidd**, an original member of the staff of St. Elizabeth's Hospital, and a pioneer in the specialty of ENT, died at the age of 74.

Editor's Note: Somewhere between 1955 and 1960, the Society determined that they would discontinue publishing the *Bulletin* during May (because of the OSMA Meeting) and July and August (because of vacations). For this reason, we are unable to bring you excerpts from the *Bulletin* for these months.

Robert R. Fisher, M.D.

Robert R Fisher MD

New Members

David S. Anderson, MD
Emergency Medicine
Office: 500 Gypsy Lane
Phone: 740-3731
MED. ED: Medical College of Ohio, Toledo, DH
INT: Metro Health Medical Center, Cleveland, DH
REDCY: Metro Health Medical Center, Cleveland, DH
SPONSORS: J. James Anderson, MD
James T. Amsterdam, MD
Arturo Mirasol, MD

Fred S. Chen, MD
Physical Medicine & Rehabilitation
Office: 345 Dak Hill Avenue
Phone: 740-4489
MED. ED: University of Illinois, Chicago, IL
INT: Wadsworth VAMC, West Los Angeles, CA
REDCY: University of California Irvine Medical Center, Drange, CA
SPONSORS: Jane F. Butterworth, MD
Anthony Pannozzo, MD
Parduman Singh, MD

Antoine T. El-Hayek, MD
Obstetrics and Gynecology
Office: 3660 Starr Centre Drive #2
Phone: 533-5585
MED. ED: Lebanese University School of Medicine, Beirut, Lebanon
INT: Lebanese University Hospital Affiliates, Beirut, Lebanon
INT: Central Military Hospital, Beirut, Lebanon
REDCY: St. Charles Hospital, Beirut, Lebanon
REDCY: St. Elizabeth Hospital, Youngstown, OH
SPONSORS: Simon W. Chiasson, MD
Nicholas M. Garritano, DD
William Moskalik, MD

Edmund S. Petrilli, MD
Gynecologic Oncology
Office: 1044 Belmont Avenue
Phone: 480-3194
MED. ED: University of Pittsburgh, Pittsburgh, PA
INT: University of Pittsburgh Health Center, Pittsburgh, PA
REDCY: Magee Women's Hospital, Pittsburgh, PA
REDCY: Presbyterian University Hospital, Pittsburgh, PA
FELLOW: LAC/USC Medical Center, Women's Hospital, Los Angeles, CA
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Robert C. McClusky, MD
C. Wesley Stone, MD

From the Desk of the Editor *(cont. from pg. 4)*

would be lower. Also, physicians would want to discharge the patients sooner in order to keep their patients happy, since that would be good for their business.

If such a system were successful in controlling costs, then perhaps foolish and expensive bureaucratic reimbursement systems like DRGs would become obsolete; and 3rd party payors would base their payments on H.O.P.S. or a negotiated percentage thereof.

Finally, under such a system, non-participating advanced facilities would undoubtedly exist for those who could afford to purchase their services, or for those who needed them on an occasional basis. These facilities would have the right to charge for their services based on supply and demand, and the populace would have the right to purchase these services outside the H.O.P.S. system. This supply and demand system, which has always existed in this country, has proven to be the most effective way of creating progress.

Robin L. *Hillier*, a certified public accountant for AM-CARE HEALTH, INC. was selected as a presenter for the American Health Care Association's Annual Convention and Exposition, to be held in Honolulu, Hawaii in October. Ms. Hillier, who handles third-party reinbursements for Am-Care will be speaking on the topic of Managed Care: A Guide to Pricing, Contract and Outcomes.

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